STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004001	A. BUILDING: _____ B. WING _____	C 05/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR RIDGE	2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was the investiagtion of Complaint IN00147987. Complaint IN00147987 - Substantiated - no deficiencies related to the allegation are cited. Survey date: May 1, 2014 Facility number: 004001 Provider number: 004001 AIM number: N/A Survey team: Gloria J. Reisert, MSW, TC Gwen Pumphrey RN Census Bed Type: Residential: 38 Total 38 Census Payor Type: Medicaid: 25 Other: 13 Total 38 Residential Sample: 02 Windsor Ridge was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00147987. Quality Review 05/02/14 by Lisa McColly	R 000		